IMPACT OF A CHANGING HEALTH CARE ENVIRONMENT ON THE NATIONAL CENTERS OF EXCELLENCE IN WOMEN'S HEALTH

The National Centers of Excellence in Women's Health (CoE) were established by the Office on Women's Health, within the Department of Health and Human Services in 1996. Their mandate is to establish and evaluate a new model health care system that unites women's health research, medical training, clinical care, public health education, community outreach, and the promotion of women in academic medicine around a common mission – to improve the health status of diverse women across the life span.

In order to be viable, the CoE clinical care centers must profitably collect reimbursement for the care they provide. This pamphlet examines the impact of a changing managed care environment on the CoEs' ability to provide integrated, interdisciplinary, women-friendly, women-focused health care.

- **Boston University Medical Center**

  The Women's Health Group (WHG), the chief clinical care center (ccc) of the CoE, continues to expand clinical care services. The Women's Health Group has successfully addressed the reimbursement reduction by successfully addressing the budget while continuing to monitor quality of clinical care, and continuing in its missions of medical education, research, and outreach to underserved and minority communities.

During the designation as a National Center of Excellence in Women's Health, the Women's Health Group has shown tremendous growth. The practice has grown from 6231 visits annually in 1999- 2000, to the current annual visit rate of 6477 for 2000-2001.

Increases in practice schedule time by lengthening number of patient hours for each provider has increased provider availability. Given the 15-18% no show rate in the practice, the CoE has increased the double booking protocol. With increased support from the Department of Medicine, it increased the number of FTE support staff by an additional nurse. The new nurse position, responsible for a greater number of telephone calls, and prescription refills, has increased the availability of physicians and the nurse practitioner for office visits. There have not been increases in provider sessions, and through attrition, the CoE has decreased some of the physician clinical hours.

These increases in volume have occurred without reduction in the teaching mission of the practice, and there continue to be increased numbers of trainees completing rotations. Rates of uninsured women, minority women, and women without proficiency in English have increased. The research mission continues with additional protocols supported for patient enrollment. Community outreach focuses on services to underserved communities, especially those with low proficiency in English.

These accomplishments reflect the benefits to the CoE of institutional support to the mission, including financial support of the practice, and service support including interpretive services that are available for 17 languages and are on-call 24-hours per day.

These accomplishments also reflect the benefit of the OWH support for research, medical education, and community outreach missions, which due to reductions in reimbursement to teaching hospitals are no longer supported by reimbursement.

- **University of California at Los Angeles**

The National Model Center of the UCLA National Center of Excellence in Women's Health is the Iris Cantor-UCLA Women's Health Center. Founded in 1995, in 1998 it became part of the Primary Care Network (PCN) of UCLA. The Iris Cantor-UCLA Women's Health Center (WHC) offers comprehensive primary care to women, as well as specialized, multidisciplinary consultation. Consultation occurs as part of the Specialty Women's Clinic (SWC), which brings together internists, geriatricians, and obstetrician-gynecologists to address issues of menopause, osteoporosis, and incontinence. Bone densitometry, phlebotomy, and office urodynamics are offered on site. As part of the PCN, the WHC participates in numerous managed care contracts, as well as preferred provider, Medicare, Medi-Cal (California Medicaid) and traditional fee-for-service arrangements.

The CoE Clinical Care Center, the Iris Cantor-UCLA Women's Health Center, is part of the Primary Care Network of UCLA. As such, it receives its budget from the Primary Care Network. It is primary care based, staffed by internists and geriatricians providing comprehensive care, as well as provides specialty services on site (evaluation of osteoporosis, incontinence, menopausal issues, and infertility; office urodynamics and DEXA scanning), as well as coordinates with other adjacent/community women's health specialists (e.g., the Iris Cantor Center for Breast Imaging mammography), the Revlon-UCLA Breast Center (multidisciplinary breast care), the Women's Life Center

(psychiatric services), the UCLA Department of Obstetrics and Gynecology, and others).

The CoE does not contract directly. All outpatient provider services at UCLA are contracted for by the UCLA Medical Group. Physicians at the CoE are members of the UCLA Medical Group. Although aspects of these contracts do hinder an integrated model of care (e.g., in many contracts, mental health specialty services are "carved out", meaning primary care providers cannot directly refer to mental health specialists or influence which mental health specialists are used), direct contracting by the CoE would be highly unlikely to change these aspects, they are common to contracts with all providers in California. Approximately 25% of our patients are covered by Medicare, and approximately 10% are Medi-Cal (fee for service California Medicaid) or managed care Medi-Cal (California Medicaid patients cared for by managed care organizations). Our physicians also see patients at the Burke Clinic, which serves 100% medical assistance, self-pay, free/charity care, and Medi-Cal patients, and a CoE Clinical "satellite" clinic has just been established there.

Approximately 10,000 patients are seen yearly at the CoE clinical care center. The capacity of the center has been reached, further growth will be at satellite sites. Racial Demographics of UCLA National Model Center:

	National Model Center 1996	National Model Center 2001	LA Local Area	County* of UCLA**
White/ Latina	72.6%	67.68%	57%	78%
Black	9.3%	10.43%	11%	6%
Asian	10.4%	11.97%	11%	9%
Native American	0.9%	2.04%	5%	N/A
Other	6.4%	7.89%	21%	N/A

NOTE: Figures add to greater than 100% because of rounding

* 1990 Census Data

** 1990 Census Data including Malibu, Pacific Palisades, Bel Air, Brentwood, Beverly Hills, Santa Monica, Culver City, Venice, Century City, and contiguous parts of Los Angeles

The percent of patients who identify Spanish as their primary language is 10.51%.

Age Demographics of The Iris Cantor-UCLA Women's Health Center:

	National Model Center 1996	National Model Center 2001
0-17 years	0.1%	0.16%
18-34 years	27.1%	23.31%
35-44 years	21.5%	18.27%
45-55 years	25.6%	26.91%
56-70 years	16.2%	20.81%
70+ years	9.5%	10.54%

Estimated percentages of contracts at the CoE include:

50% HMO managed care

20% Fee for service Medicare

5% Fee for service Medi-Cal (Cal. Medicaid)

25% PPO (also managed care)

The percentages have not changed significantly since the start of the CoE, except growth in HMO Medi-cal (California Medicaid) patients.

The institutional commitment to women's health remains strong, but all clinical programs have been affected by reductions in reimbursement, and women's health is no exception. These forces have resulted in less time for teaching, less time with individual patients, and greatly reduced resources for things like community education.

◆ **University of California, San Francisco**

The UCSF Women's Health Center provides multiple services to women in an eight-story building. We currently see patients in the following clinics: Mammography, Primary Care, and Obstetrics-Gynecology. Patients are also seen in specialty clinics, including Dysplasia, Gyn-Oncology, continence Center, Fibroid Center, Ultrasound, the Center for Reproductive Health and Fertility, and the IVF Clinic.

The Resource Center has a comprehensive lactation program to increase access to information and resources related to breastfeeding for new mothers. Recently a contract has been negotiated with one of the local Medi-Cal managed care companies to include breast pump rentals as a covered benefit in order to support lower income women in continuing to breastfeed. In addition, the Resource Center has assumed oversight and responsibility for the employee breast pumping stations available across the UCSF campuses. Information about these stations and the support available through the Resource Center is provided to all UCSF employees when they go on maternity leave.

Patient volume at the UCSF CoE, inclusive of OB-GYN, Fertility, Genetics, and Primary Care, for 2002 was 54,200. Of these, there were 9,900 women's health visits.

Rough estimates of the ethnicity and age mix of the patient population are:

Of the approximate 4200 patients seen during the period July 1, 2001-June 30, 2002 (The population served is predominantly Russian and Chinese population due to the CoE's proximity to San Francisco's Chinatown and Russian Community Center) -

48% were White
25% Asian Pacific Islander
12% Other
10% Unknown
6% African-American
Under Age 30 22%
31-40 33%
41-60 37%
Over 60 9%

Under the leadership of a PharmD CoE affiliate, the UCSF CoE developed a model curriculum for a one year Pharmacy Residency in Women's Health. Funding was obtained to continue this program into its third year. This Pharmacy Residency provides multidisciplinary training with the following goals: 1) to provide proactive, specialized drug-therapy management skills to improve patient understanding, and adherence to pharmacotherapy regimens for women; 2) to explore a new role for pharmacists in the co-management of women's pharmacotherapies that can be reproduced within managed care and integrated group practices, and 3) to teach research methods regarding clinical trials of innovative pharmacotherapies to improve the health of women from diverse ethnic and social backgrounds.

◆ **Harvard University**

The main HMS CoE Clinical Care Center is located at BWH at Women's Health Associates. Women's Health Associates is one of several hospital-based practices that are owned and operated by the hospital. All the physicians, nurses and support staff are hospital employees. The hospital collects all revenue and bills for all services.

The internal medicine practice provides comprehensive primary care to adult patients. The practice consists of eight female physicians that are board certified in internal medicine, and several that are sub-specialists in endocrinology. Each patient is followed by a primary care physician and receives individual assessment, treatment options, education and mutually established goals. The scope of patient care is based on appropriate ambulatory interventions, specialty referrals, and ongoing evaluation of treatment modalities. Although the physicians have a special interest in women's health, they provide comprehensive care for both acute and chronic illnesses. Minor procedures are performed within the practice (e.g., cryotherapy, anoscopy etc.) but not those that require general anesthesia or conscious sedation. The gynecology practice provides general and specialty care, and minor, routine, ambulatory procedures to adult patients. The scope of care is appropriate to ambulatory practice standards. General anesthesia and conscious sedation are not performed on site. All other surgical interventions are provided in BWH surgical suites. The three board certified gynecologists have expertise in benign gynecologic surgery, management of abnormal Pap smears, the evaluation and treatment of abnormal uterine bleeding, treatment of uterine fibroids and ovarian cysts, contraceptive techniques, and menopause management. In addition, subspecialty expertise is provided for evaluation and management of urinary incontinence

and pelvic floor support defects (uterine/vaginal prolapse, cystocele, rectocele). Urodynamic testing is available.

The CoE does not contract directly with any managed care or other organizations. The WHA contracts are all part of the contracts negotiated by Partners HealthCare, Inc., the parent company of Brigham and Women's Hospital. The integrated model of care is a core value of WHA and has been since its inception. In general managed care has not inhibited this since managed care contracts tend to foster care that takes place all in the same system. Commercial insurance covers 42% of patients managed care organizations covers a third of the patients, and Medicare covers 13%. A small percentage of patient visits are covered by Medicaid, and very few are in the category of self-pay. Although free care is available, far less than 1% of patient visits are recorded as such.

Primary care practices at BWH are expected to be financially solvent while maintaining high standards for clinical care and patient satisfaction levels. Attempts to balance revenue and expenses in all primary care practices have led to initiatives such as, physician and support staff coding education sessions, systematic upgrading of medical records, the institution of productivity measures, and periodic assessments of patient satisfaction to optimize the operation of the practices. The practice focuses on productivity as measured by relative work units per visit instead of tracking only numbers of visits. The WHA physicians had a productivity level at an annualized value of 1.16 rvu (relative value units)/visit in FY 2001. This represented a 7.3% increase in productivity over the last annual period. Approximately 12,000 patient visits occur annually. The largest percentage of patient visits is from the 20-44 age group. An accurate determination of

the racial/ethnic identity of the patient population continues to be difficult to accurately quantify. This is due to a large group of patient race captured as "not specified" in the patient database. The "not specified" category represents 35% of the patients. If the "not specified" category of patients utilizing the CoE practice is eliminated, Caucasian women made up the greatest percentage of patients (65%). The next largest percentage of patient visits is African American women (24%). Latina, Asian and other populations represent less than 1% each of the recorded patient population. Because the capacity of the practice has been reached there is little room for growth at this time.

BWH conducts patient satisfaction surveys in primary care practices as part of an ongoing effort to ensure high satisfaction as productivity increases. The CoE practice has high satisfaction levels with the clinical services provided. The practice is not viewed as positively for issues such as parking, billing, and systems issues over which the practice has little control. The results of the patient satisfaction survey from all the BWH primary care practices are provided for comparison. Clinical practice standards are frequently reviewed to ensure adherence to internal guidelines or accepted national guidelines. Quality monitoring and patient satisfaction are foremost concerns of practice. A computerized medical record provides documentation of patient encounters and information to assist in collecting practice data. Quality of care measures that are used to track practice standards include mammography screening, Pap smear screening, cholesterol screening, and tobacco use screening.

Patient Satisfaction Trend

Score includes both "Excellent" and "very good" responses
FY 1999 - FY 2001 (Data collected in fall 1998 and winter 2001)

	Harvard CoE			All Primary Care	
	FY 1999	FY 2001	Change*	FY 2001 Ave.	Difference**
Physician					
Overall care	91.0%	96.8%	5.8%	92.7%	4.1%
Technical skills	93.1%	95.7%	2.6%	91.5%	4.2%
Courtesy/respect	94.4%	98.4%	4.0%	94.0%	4.4%
Explanation of dx/plan	91.2%	93.8%	2.6%	90.2%	3.6%
Amount of time	85.2%	87.0%	1.8%	84.6%	2.4%
Clear follow-up plan	90.4%	93.9%	3.5%	89.5%	4.4%
Communication re: test	N/A	80.0%	N/A	79.3%	0.7%
Practice Staff					
Overall care	84.7%	90.7%	6.0%	86.2%	4.5%
Phone courtesy	73.6%	85.6%	11.4%	79.9%	5.1%
Registration efficiency	74.3%	85.3%	11.0%	81.8%	3.5%
Check-in courtesy	79.0%	90.2%	11.2%	83.3%	6.9%
Med. assistant courtesy	81.6%	93.9%	12.3%	87.3%	6.6%
Access					
Telephone access	60.0%	63.3%	3.3%	61.1%	2.2%
Appointment access	59.7%	70.4%	10.7%	72.0%	-1.6%
Wait in office	62.7%	68.2%	5.5%	67.5%	0.7%
Other Issues					
Signs and directions	76.9%	84.2%	7.3%	75.3%	8.9%
Parking services	68.5%	62.3%	-6.2%	56.0%	6.3%
Facilities	87.8%	90.7%	2.9%	85.0%	5.7%
Billing	75.5%	81.9%	6.4%	78.6%	3.3%
Other Measures					
Waiting time < 10 min.	51.0%	53.7%	2.7%	55.6%	-1.9%
Recommend to family	98.5%	98.8%	0.3%	98.9%	-0.1%

* A positive number that score improved

** Comparison of Harvard CoE main practice site to other primary care practice sites within the same institution (BWH). A positive number means that the CoE was better than the average.

The insurance coverage profile for all institutions at Harvard Medical School is not known. The insurance coverage for Brigham and Women's Hospital primary care practices is described below.

Type	FY 98-99	FY 02 June
Managed Care	34.3%	39.1%
Fee for service	10.4%	8.6%
Medicare	27.7%	26.1%
Medicaid	19.7%	16.7%
Uninsured	5.3%	7.6%
Self pay	2.6%	1.8%

Managed care plans held promise as a means for emphasizing preventive and primary care for populations. Managed care plans in general emphasize prevention and are more likely to cover preventive services than fee for service plans. They also emphasized population approaches to maintaining health through newsletters and other information geared toward the public. These efforts, however, often fall short in reaching the diversity of women seen in the women's health practice. Unfortunately people don't generally stay in one plan long enough for the plan to truly take a preventive approach to their care. For example, managed care insurers often provide physicians with a report of patients who are out of compliance with recommended screening tests such as mammography. Since the insurers have data based only on their own payouts for procedures they generate lists of individuals who appear to have missed a test but who had it within the recommended time frame but at a time another insurer covered them.

In general reimbursement has been a significant problem for women's health practices. As reimbursement rates have declined or plateaued more information has emerged about beneficial preventive services or care for chronic conditions. Providers are encouraged to limit testing and prescription medications, yet mammograms, screening, colonoscopy, and bone densitometry have all been accepted as important preventive care for women. Advances in the management of heart disease, hypercholesterolemia, arthritis, and diabetes support prescribing expensive medications for secondary prevention and management. Physicians who see a preponderance of women patients, especially women with chronic problems such as diabetes and hypertension, incur higher costs for medications, testing, referral, and inpatient care. Pregnancy and infertility also result in higher costs per member, per month. Mental health coverage has been a significant problem due to lack of adequate number of mental health providers. It is difficult for providers to provide or recommend the range of comprehensive services for women that reflects the highest quality of care and hold down costs. These cost issues are magnified for women's health practices based in academic medical centers because the women are generally sicker than populations in non-academic centers or community settings.

The cost share for the Center of Excellence contract is a difficult requirement given the current declining revenues taken in by academic centers and declining operating (or negative operating) margins. Primary care in general, and women's health specifically, has not been a revenue generator for academic medical centers. The emphasis on technological interventions and tertiary and quaternary care stems from a reimbursement system that rewards intervention rather than prevention. Reimbursement for mammography and breast cancer surgery is inadequate to support

these fields. Ironically as more women have entered breast cancer surgery as a surgical specialty the reimbursements for these types of surgeries have declined or plateaued.

Harvard is committed to excellence in women's health and has made a commitment to the Center of Excellence concept. Moreover, the institution has worked diligently to identify opportunities to support the Center of Excellence and the cost share.

- **University of Illinois at Chicago**

  The Center for Women's Health at the University of Illinois at Chicago offers a variety of services under one roof. Within the Center itself we offer services for Ultrasound, Family Planning, General GYN, OB High Risk (Antenatal), Normal OB, Genetics, Midwife Practice, Reproductive Endocrinology, Infertility, Teen Clinic, and Osteoporosis Clinic. The Center is located in the Outpatient Care Center on the University campus, all other specialties, including, Internal Medicine, Behavioral Health and The Wellness Center are also located in the same building. This allows for our clients to have all services under one roof.

  The Center for Women's Health employs registered nurses, nurse midwives, licensed practical nurses, sonographers, medical assistants, nutritionist, social worker, clinical researchers, and genetic counselors. The Director of Physician Practice is also a registered nurse with a graduate degree in business administration; this position works closely with the Medical Director for Women's Health to provide state of the art services. The Department of OB/GYN, state funds, subsidies, and grants support the Center financially.

The current payor mix at the Center for Women's Health is as follows:

Capitated managed care contracts: 0.21%
Managed care: 33.31 %
Fee for service: 2.14%
Medicare: 1.39%
Medicaid: 55.08%
Other: 7.86%

In 1997 when we first became a CoE, Women's Health was divided into a private practice and continuity of care clinic. At that time the payor mix was as follows:

Private Practice	COC
Commercial – BC 8.8%	Commercial – BC 2.7%
HMO/PPO 56.5%	HMO/PPO 18.6%
Public Aid 25.6%	Public Aid 63.6%
Medicare 3.3%	Medicare 1.9%
Other 5.8%	other 13.1%

The managed care contracts and fee for service agreements have not helped nor hindered the CoE's ability to provided integrated care to women's.

This year we have had approximately 36, 000 visits to providers at The Center, 45% Hispanic, 45% African-American and 10% a mix of ethnic groups, age range 14 to 70 years old. Our no show rate is 50%, with the largest percentage in the GYN and postpartum departments. We follow-up with our no shows by calling the client to reschedule appointments.

As we offer more educational opportunities to our population we expect the numbers to grow. A new development of homes is being built in our community; these new homeowners will increase our numbers and increase the private insurance percentage of our payor mix.

I believe that the advantage of managed care over other payor mix in providing integrated care for women would be the increased revenue. The drawbacks to the current conditions, state and federal cut backs of course are the lack of funds to provide increased staffing and better educational material. The changing environment has not impacted the institutional commitment to our CoE at the University of Illinois. We have learned to be creative and develop quality programs for clients that are cost efficient. We are about to start a program to teach our clients how to use a computer, how to access health care information via the Internet and community resources for use of computers. We participate in community health fairs and hospital based fairs. Overall the opportunities are endless even with the recent cut backs in funding.

- **Indiana University**

The Indiana University CoE is supported by IUSM and the Wishard Health Services. It is a dedicated clinic, with receptionist, waiting areas, nurses, patient exam rooms, a conference room, a bone densitometer, dedicated continence care rooms (with equipment) and physicians.

The Indiana University CoE does not contract directly with any insurance, HMO or other health care payment organization. All negotiations are conducted by IUSM or Wishard. Patient coverage is 20% Medicare, 9% Medicaid, and 48% free care/charity care,

20% commercial insurance, and 3% self-pay.

The CoE clinical care facility had seen 31,736 patients as of 30 June 02. Ethnic mix is approximately: 31% African American, 3% Hispanic, <1% Asian, 56% Caucasian, 7% "other." Age mix is approximately: <1% age 13-19; 13% age 20-30; 15% age 31-40; 24% age 41-50; 24% age 51-60; 12% age 61-65; 11% age 66-75%; 4% age 76-85.

HMO and managed care is very rare here. The CoE population reflects that of the Wishard Health Services, except that there are somewhat more commercially insured women (reflecting the growing attraction of the CoE clinic to our faculty, staff, and women who work in downtown Indianapolis).

The cost share does not affect our clinic operations. The institutions are committed to the CoE.

- **Center: Magee-Womens Hospital**

The Magee-Womens Hospital's Center of Excellence in Women's Health clinical care sites includes its outpatient clinic and Comprehensive Center for Women with Physical Disabilities at the Magee site. In addition, four Womancare centers: north, south, east and west provide service as well as five neighborhood centers and a university site at Montefiore Hospital. All sites are part of Magee-Womens Hospital of the University of Pittsburgh Medical Center Health System (UPMCHS) and are supported operationally as such.

The Magee CoE does not contract directly with managed care organizations. The indirect relationship through the health system helps the CoE's mission to establish an integrated model of health

care for women at the CoE site but also extend its leadership tothe UPMCHS. The percentage of patients covered by managed care contracts grows yearly. At the end of fiscal year, 6/30/01, managed care accounted for 69.47% (gross charge basis) and 71.96% as of 6/30/02. As you would expect fee for service decreased in the same period from 7.5% to 6.24%. Medicaid has remained consistent at 4.29% and 4.30%. There is growth in the Medicare sector from 5.35% to 6.47%. Charity remains one percent and self pay two percent. The other category is 8.03% that includes commercial PPO's and many other contractors.

In 2001-2002 approximately 50,000 patient visits occurred combining the main outpatient site and the five neighborhood clinic sites. Overall the ethnicity mix is 49% Caucasian, 49% Black and 2% other. This varies greatly by neighborhood; for example, at our Hill House clinic it is 90% Black and 10% Caucasian and the South Side clinic is 85% Caucasian and 15% Black. Most patients are in the 19 to 35-age range but the 40 to 65-age range is growing. The Magee CoE's growth trends are in non-obstetrical patients. The addition of new services like Bariatrics and women's gastrointestinal disorders accounts for our growth as well as growth in women's cancers. With the closing in September 2002 of the areas largest behavioral health provider there is potential growth in this area. Group practices have merged to become larger with several practices having over 10 providers. The "no show" rates vary by site. At the main site they average 50%.

Reimbursement for care in general limits our ability to provide integrated, women-friendly, women-focused health services. This is particularly true in the areas of behavioral health and treating women with physical disabilities and the comprehensive care they

often need. Of major concern are the uninsured and underinsured women age 40-65. Title 5, 10 and 20 funding streams for basic care like pap smears, breast exam, education and counseling help. These women include the working poor both uninsured and those who are insured with high deductibles. Our advocacy agenda continues to address these issues on a statewide basis. On-going meetings with the Pennsylvania legislature are currently advocating for a Pennsylvania Office of Women's Health.

The changing healthcare environment is a challenge that all health care institutions face including the Magee CoE. Our commitment to improving healthcare for women in Western Pennsylvania grows with our reputation of delivering quality women focused healthcare. Leadership in shaping women's health research with the Magee Women's Research Institute adds value to medical education and the clinical care provided at the Magee CoE.

Magee-Womens Hospital continues to utilize patient satisfaction surveys. During the national CoE patient satisfaction focus group project, the evaluation specialist, along with others on the national evaluation team, determined that many patient satisfaction surveys from various health institutions displayed a positive bias in the wording of the survey questions. No matter how unintentional this bias may be, there is no denying that positive data can be useful, from a marketing perspective, to an institution's ability to claim success. The Marketing and Communication Department conducted a series of age-specific focus groups in late summer of 2000 using an outside agency to see how consumers view Womancare. This information is being used to shape the strategic planning of the MWH Vision 2004.

As healthcare costs continue to rise and managed care becomes

more pervasive, service evaluation will become even more important in balancing the bottom line. The CoE evaluation specialist will continue to work closely with the hospital administration on an ongoing evaluation plan to truly understand strengths and address weaknesses.

- **MCP Hahnemann University (doing business as Drexel University)**

  The MCPH CoE clinical site is independent of any traditional department in the College of Medicine. It is a separate entity directly under the Dean's office, supported by revenue from patient care and a subsidy from Tenet Healthcare, Inc.

  The clinical site does not contract directly with any insurance company. This has not had any effect on its ability to establish an integrated model of health care. The percentage of patients covered by Medicare is 15%, Medicaid – 15%, free care/charity care – 5%.

  In 2002, the University had 40% managed care contracts; 25% fee-for-service contracts; 15% Medicare contracts; 15% Medicaid contracts; and 5% with no insurance. This is no different from the percentages at the start of the CoE.

  There are no benefits of managed care plans over fee-for-service plans in providing integrated care to women across the life span. However, reimbursement for care has limited the CoE's ability to provide integrated women-friendly services.

◆ **University of Michigan**

The University of Michigan Health System (UMHS) CoE includes all clinical, research, and education components of the UMHS Women's Health Program. In addition to support provided by the DHHS OWH, the Center of Excellence is supported by the Medical School (faculty time) and the Health System (space, budgetary support). The core clinical center is co-located in the Obstetrics and Gynecology clinic and the Women's Health Resource Center occupies space adjacent to the clinic.

The CoE does not contract directly with any payors – all contracting is done centrally through the contracting office within the Health System. This does not impact the CoE's ability to establish an integrated model of health care for women and if anything, helps to ensure that we are able to offer services and plan programmatic opportunities without regard to the specific requests of individual payors. The majority of clinic patients have some level of medical insurance. The breakdown is as follows and has not remained unchanged during the duration of the CoE (estimated based on FY2000 activity):

Medicare:	7.9%
Medicaid:	14.4%
Self pay/FFS/commercial:	73.0%
No insurance	5.0%

The core clinical CoE site records over 35,000 primary and routine care visits each year and about 20,000 specialty visits. An additional 30,000 clinic visits are recorded in each of the satellite health centers. In a typical year, the breakdown of our patient population by ethnicity is approximately as follows:

White/Caucasian	82.9%
Black/African-Amer	8.7%
Hispanic/Latina	2.7%
Asian/Asian-Amer	8.7%
Native American	0.6%

Regarding growth trends, the clinic volumes continue to increase each year. These increases have been steady since receiving the CoE designation.

Regarding benefits and drawbacks of managed care plans over fee-for-service plans in providing integrated care to women across the life span, the UMHS CoE is fortunate to work closely with the university-owned managed care plan, M-Care. Their outreach and community presence are visible, trusted, and well respected and they assist the CoE in co-sponsorship of events, activities, screenings, etc. Approximately 65% of the clinic population served has managed care coverage. The majority of these patients is covered by M-Care and M-Care allows self-selection and self-referral to UM providers for routine women's health care (annual exams, etc.). This is very helpful to the population and removes the barrier of two visits (one to the PCP and one to the gynecologist).

The CoE cost share requirement and other factors like reimbursement legislation have not directly impacted the institutional commitment the CoE or to women's health in general. If anything, the institution has prioritized women's health and through in-kind support and other gestures demonstrates that it values our women's health programming.

- **University of Puerto Rico, San Juan, Puerto Rico**

  The University of Puerto Rico CoE Women's Health Clinic continues to expand its clinical care services, continues to monitor quality of clinical care and to pursue its mission of medical education, research, and outreach to underserved populations.

  Since receiving the designation as a National Center of Excellence in Women's Health, the Women's Health Center has grown exponentially. The number of patients that visited the Center in 2000-2001 was 4,931. In 2001-2002, the number of patients' visits increased to 5,296, which represents a 10% increase over the previous year. Patients seen at the Women's Health Center range in age from teenage to 90+. The Center provides care to patients regardless of their ability to pay. The majority of patients (70%) have employer-based insurance, and a significant proportion are government-funded or charity care.

  There have been no major changes in the insurance status of patients during the 2000-01 and 2001-02 timeframe. At the CoE clinical care center's practice, commercial insurance covered 70% of the patients using the Center during the 2001-02 reporting period, Medicare covered 11% and 19% were covered by local government sponsored medical assistance.

- **Tulane and Xavier Universities**

  The TUXCOE (Total Woman Health Care Center [TWHCC]) is a women's health clinic organized within the Tulane University Hospital and Clinic (TUHC) system. As part of the TUHC system, the TWHCC is financially supported by the hospital and is operated by TUHC employees. The TUXCOE Director oversees TWHCC operations.

TUXCOE does not directly contract with managed care organizations, HMOs, self-pay, or fee-for-service organizations. As a hospital department, the clinic participates in TUHC contracts. Because other TUHC services participate in the same insurance contracts, this relationship allows for facilitation of referrals from the TWHCC to specialty services. This has helped the CoE establish an integrated model within the TUHC system. Medicaid covers approximately 27% of TWHCC patients, 14% are covered by Medicare, 2% are self-pay patients, and the remaining 57% are covered under private insurance, including managed care organizations.

The TWHCC provider sees between 8 and 15 patients per session, depending on the types of patients on the schedule. Approximately 65% of the patients are African American, 28% are Caucasian, 3% are Asian or Pacific Islander, 1% is Hispanic, and 3% of patients are classified as N/A. Of the total TWHCC patient population, 40% of patients are between the ages of 41 and 64, 27% are between the ages of 25 and 40, 18% are between 15 and 24 years old, 14% are 65 years of age and above, and 1% of the TWHCC patients are infants.

The TWHCC averages between 150 and 175 patient visits per month with a no-show rate of 19%. Approximately 20 new patients are seen each month.

Within the Tulane University Hospital & Clinic, this year's average percentage of managed care contracts is 39%. Fee-for-service contracts compose 3% of total contracts, Medicare is about 26%, Medicaid is 29%, and 4% of contracts are classified as other. At the start of the CoE, managed care contracts composed about 33% of contracts, fee-for-service contracts were about 7%, Medicare was

26%, Medicaid was 27%, and about 5% of contracts were classified as other.

The benefits of managed care plans in providing integrated care to women across the life span include the fact that most managed care plans provide for well-women exams, yearly mammograms after the age of forty, and other preventive, diagnostic measures. Additionally, these plans provide for the option of a primary care physician in an OB/GYN setting, giving a woman more choices when accessing health care.

While reimbursement issues present a challenge, they have not limited the CoE's ability to provide integrated, women-friendly, women-focused health services. Personnel and systems have been put into place to coordinate and facilitate the financial processes.

Both the Health Sciences Center and the Hospital remain committed to TUXCOE and to addressing issues in women's health despite the changing external environment. TUXCOE is actively and creatively pursuing funding opportunities through grant-writing and foundation proposals to help support both ongoing and new activities.

TUXCOE co-sponsored a Medicare Program Update Seminar with Centers for Medicare and Medicaid Services, LA Health Care Review, Senior Health Insurance Information Program. This free Medicare Program Update Seminar was designed to provide the latest information about Medicare programs, rights and benefits to senior group leaders, Council on Aging staff, medical social workers, hospital discharge planners, medical clinic staff, and health education workers.

- **University of Washington**

Patients seen in the Women's Health Care Center (WHCC) represent a diverse population, ranging in age from the teenage years to 90+. WHCC provides care for patients regardless of ability to pay. The majority of patients have employer-based insurance, but as with most academic medical clinics, a significant proportion of patients are government-funded (Medicare, Medicaid, Washington State-sponsored Basic Health Plan) or charity care. WHCC patients are Caucasian (76.1%), African American (4.6%), Asian American (5.9%), Native American (0.4%), Hispanic (1.8%). During the past fiscal year there have been 673 requests for in-person interpreting: 22% Russian, 16% Spanish, 11% Mandarin, 10% Korean, 5% Vietnamese and 5% Cantonese. The remaining 31% of requests were for other languages, such as Somali, Tigrinya and Amharic.

Utilization of the University of Washington Medical Center's Women's Health Care Center services is tracked through the Mind Access Project (MAP) database. Patterns have remained stable, with approximately 40% public insurance programs (Medicare/ Medicaid/Washington State Basic Health Plan) and 15% utilization of interpreter services. However, the clinic continues to experience overall growth, with over 10% increase in visit volumes, and highest reported space utilization index in the UWMC Roosevelt Outpatient Clinic.

The Harborview Medical Center's Women's Clinic (HMC WC) is known throughout the system for its multicultural waiting room, where international clothing styles and language are the norm. During the 1999 calendar year, interpreters were provided for over 83,000 medical encounters within the institution. The languages most frequently used include: Spanish, Vietnamese, Somali,

Cambodian, Amharic, Cantonese, Russian, Tigrinya, Punjabi, Oromo and Tagalog. HMC Interpreter Services database continues to show an increase in services across the entire institution over the past year, despite persistent budget cuts. The patient ages range from 13 to 90+. In 2000, 3% were 13-18, 65% were 19-39, 30% were 40-64 and 2% were over 65. More than 40% of patients are Medicaid recipients, at least 10% receive Medicare and 26% are on low-income allowance. Over the course of the year 2000, the Women's Clinic saw approximately 41% African and African-American, 36% Caucasian, 10% Asian, 8% Latino and 1% Native American women for a total of 13,016 visits. Ongoing organizational and administrative efficiencies account for these trends.

Harborview Medical Center's Women's Clinic utilization patterns as analyzed through the Mind Access Project (MAP) have remained stable over the past year with more than 50% Medicare and Medicaid patients and more than 50% non-English speaking minorities. Referrals for colposcopic evaluation remain stable with over 200 referrals from the community clinics for this service. UWPN referrals for surgeries and procedures remain stable at approximately 200 women seen per year. Services to patients from the jail remain stable with over 60 women served per year.

- **University of Wisconsin-Madison**

The UW Women's Health Center is structured/organized/ supported by the UW Health University of Wisconsin Hospital and Clinics, a self supported public authority. The Women's Health Clinic is one of 80 outpatient specialty clinics within the system.

The CoE does not contract directly with any clinical entities, but

Unity is the name of the HMO that UW physicians Medical Foundation and UW Hospital are part. Patients that are not part of Unity can also be seen at the UW Clinic and all the Medicare patients are fee-for-service. Participation in an HMO has some advantages and disadvantages in facilitating an integrated model of health care for women.

In 2001, the UW Women's Health Center served 32,408 patients. The age distribution continues about 10% under 18 years, 17.5% 18-29 years, 17.5% 40-49 years, 17.5% 50-64 years, and 20% age 65 years or older. The ethnic distribution is 55% Caucasian, 10% African American, 10% Hispanic/Latina, 220% Asian/Pacific and 5% Native American. Since the program's inception, the program has grown exponentially averaging 12-14% per year. The year 2001 was an exception in that there was an 8% decrease in volume (4531), which can be attributed to the abrupt departure of 3 fulltime OB/GYN practitioners and 1 fulltime OB/GYN NP. In 2002, replacement staff was recruited and growth resumed exponentially. The current no show rate is 3%.

UW Women's Health averages 54% Capitated and Contracted (HMOs), 185 Meidcare, 15% Medicaid, 13% Commercial Insurance and 5% self-pay. With the University and tertiary care status, there appears to be no direct or indirect relational impact on the ability to care for the women served.

The major benefit of managed care plans over fee-for-service (other) is less paperwork for the patients and reduced costs for medications that are covered by the managed care plan. Drawbacks, however, are numerous and include:

(a) It can be difficult to refer a patient to a specific physician for consultative care even the primary care provider believes that

provider would give the best consultation or achieve the best surgical outcomes.

(b) The number of visits to ancillary health services which may be crucial in treatment and prevention of recurrences are limited (e.g., physical therapy, counseling).

(c) It is quite cumbersome and time consuming for both the pharmacist and the provider to order a drug that is not on formulary even though it may be the best drug, dose, or delivery method for that particular patient (e.g., many Asian patients have lower BMI's than Caucasian or African American patients, but some formularies do not carry the lowest dosage preparation of a drug and/or the larger dosage preparation that is carried cannot be cut in half).

(d) when clinics merge, if any of the facilities are Catholic, access to the full range of reproductive health services suddenly dissolves for all the women in the plan.

At the UW Women's Health Center, there hasn't been any reimbursement limitations placed on the CoE's ability to provide services.

The CoE contract cost share and tapering will curtail the CoE's ability to fund small amounts of salary for the clinical staff so that it will become more difficult for them to find time and motivation to come to the table as they work together to keep women's health and women's health research front and center within the medical center.

The main lesson learned is that there must be funding for infrastructure, i.e., at least partial salary support for several key

leaders ("champions") in positions to leverage additional institutional commitment as well as salary support for administrative personnel.

At Meriter, approximately 8000 women were seen, of which 20% were Medicaid/medical assistance, 10% had no insurance, and 40% were privately insured or part of an HMO. Eighty per cent of women served were less than 40 years of age.

- 55% were non-Hispanic white
- 10% African American
- 10% Latina/Hispanic
- 20% Asian/Pacific Islander
- 5% Native American.

The largest number (70%) were privately managed care or HMO and 7% were Medicaid/Medicare or medical assistance. Although the diversity of populations seen at the satellite sites was similar, the payment sources and average ages of patients differed. Forty five per cent of women were less than 30 years of age, and 38% were older than 50 years.

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Boston University Medical Center, Phone: 617-638-8035
Internet: www.bmc.org

University of California, Los Angeles, Phone: 800-825-2631
Internet: www.med.ucla.edu/womens/

University of California, San Francisco, Phone: 417-885-7273
Internet: www.ucsf.edu/CoE

Harvard University, Phone: 617-732-8798
Internet: www.hmcnet.harvard.edu/CoE/

University of Illinois at Chicago, Phone: 312-413-1924
Internet: www.uic.edu/orgs/womenshealth/index.html

Indiana University School of Medicine, Phone: 317-274-2754
Internet: www.iupi.edu/~womenhlt/

Magee-Womens Hospital, Phone: 412-641-6003
Internet: www.magee.edu/cewh2.htm

MCP Hahnemann University (doing business as Drexel University),
Phone: 215-842-7041
Internet: www.mcphu.edu/institutes/iwh

University of Michigan, Phone: 734-763-0984
Internet: www.med.umich.edu/whrc/ctr.excel.html

University of Puerto Rico, Phone: 787-753-0090
Internet: www.rcm.upr.edu/2klwhc

Tulane University and Xavier University of Louisiana
Phone: 504-585-6156, Internet: www.tulane.edu/~tuxCoE/

University of Washington, Seattle, Phone: 206-598-8986
Internet: www.depts.washington.edu/~uw98CoE/

University of Wisconsin, Madison, Phone: 608-267-5566
Internet: www.womenshealth.wisc.edu

OFFICE ON WOMEN'S HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Pamphlet Series Staff

Susan Clark, Project Officer for the National Centers of Excellence in Women's Health program; Director, Division of Program Management

Anita Broadus, Staff Assistant

Barbara James, Director of the National Community Centers of Excellence in
Women's Health Program, Senior Health Analyst

Anna Kindermann, Public Health Analyst

Sandi Lowery, Special Assistant

Eileen Newman, Public Health Analyst

Valerie Scardino, Program Manager, National Women's Health Information Center

Calvin Teel, Staff Assistant